Prior Authorization Request Form

HP Enterprise Services - Nevada Medicaid and Nevada Check Up

Inpatient Mental Health

Fax this request to: (866) 480-9903 For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____ /_____ /_____

RECIPIENT INFORMATION		
Recipient Name (Last, First, MI):		
Recipient ID Number:	DOB:	
Address:		
City:	State:	Zip Code:
Phone:	Date recipient went into DHS Custody:	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Describe recipient's current living environment, or, if already admitted, describe living environment prior to admission. ☐ Alone ☐ Foster Home ☐ Group Home ☐ With Parent ☐ Med/Surg Hospital ☐ With Non-Relative ☐ Psychiatric ☐ With Relative ☐ RTC ☐ With Spouse ☐ Unknown ☐ Other:		

RESPONSIBLE PARTY INFORMATION *(Complete this section when the responsible party is not the recipient.)*		
Responsible Party Name:		
Relationship to Recipient: ☐ Court ☐ Government Agency ☐ Parents ☐ Relative ☐ Other:		
Address:		
City:	State:	Zip Code:
County:	Phone:	

ADMITTING FACILITY INFORMATION		
Name:	Provider Number:	
Address:		
City:	State:	Zip Code:
Phone:	Fax Number:	

EPISODE

Has the recipient had prior inpatient treatment? ☐ No ☐ Yes *(If yes, enter facilities and service dates below.)*

Facility Name	**Length of Stay**	**Facility Name**	**Length of Stay**
1.	to	4.	to
2.	to	5.	to
3.	to	6.	to

Has the recipient had prior outpatient treatment? ☐ No ☐ Yes *(If yes, complete the following lines.)*

Provider Name	**Dates of Service**	**Frequency of Service**	**Outcome of Service**
1.			
2.			
3.			
4.			

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Recipient Name (Last, First, MI):			
Other Placements *(Foster Care, Group Home, Shelter, Detention, Training School, Boot Camp, etc.)*			
Facility Name	**Length of Stay**	**Facility Name**	**Length of Stay**
1.	to	4.	to
2.	to	5.	to
3.	to	6.	to

DSM IV DIAGNOSIS		
Axis I	Code:	Narrative:
	Code:	Narrative:
	Code:	Narrative:
Axis II	Code:	Narrative:
	Code:	Narrative:
Axis III		
Axis IV	*(Check all items below that present a problem for the recipient. Use the lines to write an explanation for each checked item.)*	

- ☐ Primary support group: _____
- ☐ Social environment: _____
- ☐ Educational:
- ☐ Occupational: _____
- ☐ Housing: _____
- ☐ Economic: _____
- ☐ Psychosocial and environmental: _____
- ☐ Access to health care services: _____
- ☐ Interaction with the legal system: _____
- ☐ Discharge/Decertification alternate treatment: _____

Axis V	Current GAF:

SYMPTOMS AND MEDICATIONS
Current symptoms requiring inpatient care:

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Recipient Name (Last, First, MI):			
Chronic behaviors:			
Use the lines below to list the recipient's current medications.			
Drug Name	**Dosage**	**Purpose**	**Dates Used**
1.			to
2.			to
3.			to
Precautions:			
Frequency of checks:			

REQUESTED TREATMENT

Requested Treatment: ☐ SA Rehabilitation ☐ Detoxification ☐ Inpatient Psychiatric ☐ Skilled LOC			
Are you requesting EPSDT referral/services? ☐ Yes ☐ No			
Administrative Days: ☐ Skilled ☐ Intermediate Care Level			
Admission Status: ☐ Elective ☐ Emergency ☐ Court-Ordered			
Admission Date:	Requested Length of Stay:		
Attending Physician Name:			Phone:
Inpatient services that will be provided to this recipient:			
Discharge Plan:			

HP ENTERRPISE SERVICES USE ONLY

Approved Dates:	Denied Dates:
Reviewer Name:	Title:
Reviewer Signature:	
Notes:	

Certificate of Need

REQUESTED ADMISSION DATE: _____ /_____ /_____

SERVICE TYPE: ☐ Inpatient Psychiatric ☐ Residential Treatment Center (RTC) Initial Request

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):	
Recipient ID Number:	DOB:

CASE MANAGER INFORMATION

Does the recipient have a case manager? ☐ Yes ☐ No	Case Manager Name:
Mental Health Center:	Phone:
Case Manger Signature:	Date:

ADMITTING FACILITY INFORMATION

Facility Name:	NPI:
Phone:	Fax:

CERTIFICATION STATEMENTS

A physician acting within the scope of practice as defined by State law certifies the following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient listed above.
2. Proper treatment of the recipient's psychiatric condition requires inpatient or residential treatment services under the direction of a physician.
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

PHYSICIAN CERTIFICATION *(required)*

Name:	Title:
Signature:	Date:
Additional Notes:	

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.